Ruth Ann Crystal, M.D., A P.C.
3200 Middlefield Rd, Palo Alto, CA 94306
REGISTRATION FORM

PATIENT Information

Name: _____ Date of Birth _____/ _____/ _____

Please check: ❑ Single ❑ Married ❑ Domestic Partnership ❑ Divorced ❑ Widow

Address: _____
Number Street City State Zip

Home Phone (____) _____ Work (____) _____ Cell (____) _____

Email Address _____

Your Employer: _____ Occupation: _____

Employer's Address: _____
Number Street City State Zip

PARTNER/SPOUSE's Information (if applicable) or PARENT/GUARDIAN if patient is a MINOR (child)

Spouse's Name: _____ Date of Birth ____/ _____/ _____

Spouse's Employer: _____ Occupation: _____

Employer's Address: _____
Number Street City State Zip

Work (____) _____ Cell (____) _____

_____

_____

_____

I will present a current insurance card for each visit. If such card is not available prior to services, I accept financial responsibility for all services performed. I will inform the office of any insurance changes.
I understand that presentation of insurance cards is not a guarantee of payment. Claims are subject to current eligibility and benefits review. I further agree that I am ultimately responsible for payment of services rendered, regardless of insurance arrangements. I authorize release of my medical records in order to process a claim. I authorize payment of medical benefits to the doctor. I agree that payment of co-payments, deductibles and non-covered services are due at the time that the service is rendered.
We require 24 hours notice for all cancelled appointments. There will be a $75.00 fee for missed appointments.

Patient Signature: _____ Date: _____

Emergency Contact Information (excluding your spouse)

Name: _____ Relationship: _____

Home Phone (____) _____ Work (____) _____ Cell (____) _____

Your Pharmacy: _____ City:_____ Tel: (____) _____

Who referred you to this office? _____